BOSTON MEDICAL CENTER
HealthNet Plan

June 15, 2011

Seena Carrington
Acting Commissioner
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
costtrends@hcf.state.ma.us

Dear Acting Commissioner Carrington:

On behalf of Boston Medical Center HealthNet Plan (BMCHP), thank you for the opportunity to provide written testimony in accordance with the Division's request dated May 27, 2011 under Exhibit B as provided for in Massachusetts General Law chapter 188G §6½ . We share the concerns that many have expressed about the impact rising health care costs and higher premium trends are having on the residents of Massachusetts. Although BMCHP currently does not have any commercial business, we welcome the opportunity to work with the Division on providing testimony to help inform a successful outcome of the hearing process. Because we have no commercial business, our responses to Exhibit C are not applicable.

BMCHP is licensed by the Division of Insurance as an HMO. We serve approximately 200,000 members through Medicaid and the MassHealth product and 50,000 members through the Commonwealth Connector and the Commonwealth Care product.

Our responses to the questions located in Exhibit B serve as BMCHP's written testimony. I, as a legally authorized and empowered representative of Boston Medical Center HealthNet Plan sign under the pains and penalties of perjury, that the testimony herein located at Exhibit B to the best of my knowledge is complete and accurate.

Sincerely,

Scott F. O'Gorman
Chief Financial Officer

1. **After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reason for any differences.**

   Boston Medical Center HealthNet Plan (BMCHP) covers the MassHealth (Medicaid) and Commonwealth Care population. Our book of business differs from the commercial focus of both the Price Variation and Premium Level studies.

   While we do experience price variation between providers, the extent of the difference is smaller than reported in the Price Variation study. Mass Health rates differ by provider for facility rates, non facility rates generally to do not differentiate specific providers. BMCHP leverages these fee schedules which reduces variation in cost per service across providers.

   Premium levels for both the Mass Health and Commonwealth Care populations are largely determined by the State. Trends have been lower than reported in the Premium Level study.

2. **We found that – when adjusted for all factors (benefits, demographics, geography, etc.) – small business are paying more for premiums and have experienced sharper growth in rates than mid-sized and large employers. Is this finding consistent with your organization's experience? Please comment on why you think this is happening and what can be done to assist small employers.**

   N/A

3. **What are some of the non-medical drivers (not related to health care prices or utilization) that have led to premium growth in recent years? What is your origination doing to minimize their impact on premium cost**?

   Interest in profiling and provider-centered care management has increased the need for data analysis and reporting infrastructure and clinical and quality program management. BMCHP has dedicated resources to building these functions while reducing other expenses and has reduced overall administrative costs over the past few years.

4. **What systemic actions to you think are necessary to mitigate health care cost growth and health insurance premium growth in Massachusetts?**

   BMCHP shares the general concern that the current fee for service environment has contributed greatly to the cost escalation of health care. That bring said, movement to a system with global payments and provider risk assumption at its core must be taken with care and include a thoughtful transition. Clearly perpetuating some of the price variations that are inherent in the current cost structure because of market clout would

be inappropriate. These discrepancies would need to be addressed in any transition away from fee for service.

5. **What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in order of the impact on negotiated rates.**

Factors considered in negotiating payment rates are:

1. Comparison to appropriate benchmark

   BMCHP typically uses MassHealth facility, physician and ancillary fee schedules as key comparators in the reimbursement of its providers. For hospitals, BMCHP benchmarks MassHealth inpatient and outpatient fees on the basis of the acuity of a given provider's patient population against that of BMCHP's total membership; thus hospital reimbursement is determined on a case mix adjusted basis. For physicians and ancillary service providers, BMCHP benchmarks directly against the MassHealth fee schedules for each respective provider type. As there is no publicly available fee schedule for behavioral health, rate requests are benchmarked against competitive data and existing provider agreements.

2. Network Adequacy and Provider Commitment

   Provider rate negotiations are influenced by our interest in ensuring adequate member access to providers able to accommodate their needs. Incentives such as capitation, pay for performance, and delegated care management fees may be leveraged to support the efforts of providers serving our members.

3. Provider Leverage

   Geographically isolated providers or those supporting actual or perceived specialized services may command higher reimbursement rates. In fact, the inclusion of these "highly leveraged" providers within any given network can greatly influence plan selection by members. Plans whose members' insurance premiums are fully government subsidized are particularly susceptible to provider leverage in rate negotiations, as there are no member incentives for, nor disincentives against selecting plans on the basis of network cost-efficiency. Provider leverage can also have a significant impact on a plan's ability to serve a particular population. For example, in 2009 Partners Health Care required significant increases to BMCHP's payments to Nantucket Cottage Hospital and Martha's Vineyard Hospital that could not be supported by its revenue, and BMCHP was forced to exit the Islands service area.

4. Comparison against similar providers within geographic regions

   To the extent possible, BMCHP attempts to mitigate significant variations in pricing among its providers, particularly with regard to physician and ancillary services. As such, BMCHP considers current plan rates of reimbursement of like providers within the same geographic proximity when negotiating reimbursement.

5. Current and projected utilization of services

   BMCHP considers in its negotiations, historical utilization of services, and the projected financial impact of variations in unit cost against utilization trend.

6. Acceptance of Managed Care

   BMCHP's rates may be higher than benchmark as our providers are required to comply with utilization management, coding and billing guidelines, and case management protocols inherent to managed care.

6. **Is there a material difference in how you approach contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group?**

   The approach to contracting with a health care system tends to be more strategic than is typical of single facilities or group practices, given the added complexities of negotiating for a more comprehensive array of services housed under one "roof." Since health systems generally wield greater leverage than single providers, negotiated rates tend to be higher. However, not all health systems have significant leverage. As suggested above, that leverage is influenced to a large extent (among other factors) by the availability of needed services, actual or perceived. A health system which offers little more than services already available within a region wields substantially less leverage, resulting in narrower gaps in region-wide provider pricing.

7. **We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic.**

   BMCHP's experience with its provider network supports your understanding of this dynamic, and is consistent with the recent findings of the State Attorney General with regard to those factors that influence provider leverage within the various markets and, consequently, reimbursement. Those providers who command the highest rates within BMCHP's network are those (a) whose market position is primarily influenced by geography, (b) who are highly specialized, and/or (c) who are publicly recognized

as healthcare industry "leaders." At the same time, there appear to be no discernable factors (e.g., quality or efficiency) that distinguish these providers from most other providers, and which might otherwise merit a higher rate of reimbursement.

8. **What quality measures does your organization use to assess quality outcomes by provider? What incentive or consequences are there for providers based on their performance?**

We use HEDIS measures to assess quality. They are well standardized and there are both local and national benchmarks for performance. We have had HEDIS based pay for performance bonus programs in our contracts in the past.

9. **What role do you think quality should plan in determining prices, and does the health care community currently collect the right types of quality measures?**

It is appropriate to incorporate objective quality performance as a component of provider reimbursement. Current measures are often limited by small sample size, a lack of standardized specialty measures and a lack of clinical detail on claims.

10. **We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.**

Consistent with our comments on question 4, we believe inpatient DRGs are ultimately part of a fee for service reimbursement system that has led to very expensive healthcare. Insurers have tried to implement numerous fee for service reimbursement methodologies – including DRGs – to reduce health care cost trends. While these methodologies may have experienced some short term improvements, they have ultimately been unsuccessful in holding down cost trends overall.

11. **What tools should be made available to consumers to make them more prudent purchasers of health care?**

The incentives influencing provider behavior should be transparent to consumers. This information includes how the provider is paid, whether they are at risk for cost or quality measures, and data on those measures. Specific tools that enable consumers to understand the cost of certain procedures or courses of treatment may help them be more proactive in including cost in their decision making.

12. **What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carrier to different providers for different services) from your organization's perspective? What about complete quality transparency?**

Transparency has the advantage of supporting accountability of providers and payers to consumers. Cost transparency can be difficult to define and interpret. Due to variations in cost sharing the impact of differences in contract rates upon individual

members varies greatly. Quality transparency is important in holding providers and payers accountable for their programs and incentives. It is challenging to select a set of measures that are understandable by consumers and relevant to a member when seeking specific care. Efforts to establish common definitions that are clearly explained and are comparable across reporting entities are keys to overcoming challenges to real transparency.

13. **What methods, if any, does your organization use to encourage consumers to use high value (high-quality, low-cost) providers? What has been the effectiveness of these actions?**

BMCHP has focused on supporting consumers in avoiding unnecessary utilization of Emergency Rooms and inpatient care and using in-network providers. We have found these efforts to be marginally successful.

14. **Does your organization currently offer limited or tiered network plans. If so, please describe the level of interest and/or participation from groups and individuals, as well as any feedback you are aware of from those participating.**

N/A

15. **Please respond to the trends provided in Table I.C.2b The total medical spending portion of premiums appeared to slow for 2009-2010 as compared to previous years. If your organization also experienced slowed medical spending, please explain the underlying factors. If your organization did not experience the slow-down in trends, please explain why your organization differed from the average.**

Table 20 presents a total PMPM for commercial products that is decreasing over the reporting period. BMCHP's trend has been variable over time. The experience in Table 20 may be attributable to benefit buy down and changes to the composition of the fully insured market which are not applicable to Mass Health and Commonwealth Care. The potential decrease in utilization due to member cost sharing in a tough economy is also a bigger factor for a commercial population. For our population, only some Commonwealth Care populations have a level of cost sharing.

BMCHP's 2010 over 2009 PMPM trend was negative for most of the populations we insure. Our trends were attributed to a substantial provider recontracting effort which resulted in rate reductions for many providers and favorable utilization trends driven by a light flu season and a decrease in the number births for our members. The H1N1 flu in 2009 increased that base. We also attribute the decrease in births and related services, at least in part, to the economy.

16. **Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What has been you experience and the results in terms of quality performance and cost mitigation?**

BMCHP has limited historical experience with global payments. Although some providers met their established goals, there was no mechanism for including the costs associated with settlements in the State's rate setting process and the organization moved away from these programs. We are encouraged by the Patient Centered Medical Home effort and support for shared savings and are focused on new approaches to working with providers who are able to assume risk.

17. **Please identify additional cost drivers that you believe should be examined in subsequent years sand explain your reasoning?**

Factors that should be considered in subsequent years include: technology, population risk changes, benefit changes, and cost-shifting (when there is a change in resources which increases dependence on the health insurance system). Advanced imaging, minimally invasive surgeries, injectible drugs and blockbuster drugs are examples of healthcare advances which may improve member outcomes and may increase cost and / or utilization of healthcare services. Minimally invasive surgeries may not have a higher price but more members may have knee surgeries if they are less invasive, which increases costs.

18. **Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.**

The following issues are of importance to insurers: disproportionate share hospitals, behavioral health trends, and cost savings initiatives.

Disproportionate share hospitals, using the DHCFP's 2007 categorization, represent 64% of BMCHP's hospital costs. These providers have less commercial business to support their costs and as we learned from the Price Variation study frequently have lower commercial rates. These providers have less ability to accept lower rates from BMCHP because their costs can not be shifted to commercial carriers.

Behavioral Health is not specifically considered in either report but is a significant cost and trend driver in the Medicaid and Commonwealth Care population.

Programs required to mitigate trends are costly but may have significant return. Program with the most solid ROIs have saturated the market and new opportunities may be untested. Some may be successful but decreases in funding will limit a carrier's willingness and ability to consider new programs.